Summary of Testimony by Frederick P. Cerise, M.D., M.P.H. Secretary, Louisiana Department of Health and Hospitals House Committee on Energy and Commerce Subcommittee on Oversight and Investigations March 13, 2007

Louisiana's challenge is twofold: we must first meet immediate needs while ensuring that, in the process, we support the rebirth of a better overall system of care.

• The vision for a system to replace the lost capacity is one that adheres to the aims set forth by the Institute of Medicine: safe, effective, patient-centered, timely, efficient, and equitable.

The New Orleans region health care system continues to have difficulty meeting the health care needs of its citizens, particularly the uninsured.

- The region is short at least 49 primary care providers that are available and willing to serve the Medicaid and uninsured populations.
- There is a shortage of acute care hospital beds available in the region.
- Only 180 of 274 psychiatric beds have been restored.

The immediate needs care clear – access to primary and behavioral health care, reimbursement for services, and recruitment and retention of health care professionals.

The solutions are possible: expand primary care services, reimburse providers for non-institutional care, and provide incentives to attract health care workers.

- Establish sufficient primary care capacity in a manner consistent with the redesigned system of care envisioned by the Collaborative by sustaining operational support provided by Social Services Block Grant funds to safety net clinics and by funding ten new medical homes.
- Fully support and implement the Greater New Orleans Health Services Corps Program.
- Allow the redirection of DSH funds to support non-institutional care and physician services.
- Develop, implement, and fund a five year redevelopment and mitigation / prevention plan for behavioral health services and expand Medicaid coverage to people with severe mental illness.
- Provide funding for hospitals and skilled nursing facilities for costs related to the Medicare wage index.
- Support electronic medical record (EMR) adoption and continue to support the Louisiana Health Information Exchange (LaHIE) project.
- Provide an equal number of Section 8 project-based Housing Choice Vouchers to be used in conjunction with the 3,000 units of Permanent Supportive Housing.

Frederick P. Cerise, M.D., M.P.H. Secretary, Louisiana Department of Health and Hospitals

Testimony for:

"Post Katrina Health Care: Continuing Concerns and Immediate Needs in the New Orleans Region" March 13, 2007

> Subcommittee on Oversight and Investigations Committee on Energy and Commerce United States House of Representatives

Introduction: Mr. Chairman and members of the committee thank you for the opportunity to testify today on the continuing concerns and immediate health care needs in the New Orleans region. I am Dr. Fred Cerise, Secretary of the Louisiana Department of Health and Hospitals, the leading state agency for health care in Louisiana.

Background: Louisiana struggles with the same health care delivery system issues affecting the rest of the country. Our fragmented system that operates largely in a fee for service environment results in a health care system characterized by uneven quality of care, rising costs and inequitable access to care. In 2004, Louisiana spent \$19.4 billion on health care services in Louisianaⁱ and from 2000-2006 health care premiums for Louisiana families grew nearly 5 times faster than earnings.ⁱⁱ

In many areas, capacity and utilization in Louisiana are well above the national average. A snapshot of the status in Louisiana prior to Hurricanes Katrina and Rita shows the following:

- Overall Medicare spending per capitaⁱⁱⁱ 1st
- Hospital beds per capita 9th
- Medicare hospital days 2nd
- Overall hospital admissions 4th
- Overall emergency department visits 4th
- Medicare home health, number served per capita 1st
- Medicare home health, number of visits per person served^{iv} 1st
- Overall prescriptions filled for children and elderly 3rd
- Overall Medicare quality ranking v 50th

Louisiana is further characterized by a high uninsured rate, a high level of poverty, and poor health status. The uninsured consume far less care than those with insurance, vi they are not the driving force behind the above statistics.

The largest provider of care for the uninsured is Louisiana's state operated system run by the Louisiana State University (LSU) Health Care Services Division (HCSD) and Health Sciences Center (HSC). This system is comprised of 10 hospitals and over 250 outpatient clinics statewide. LSU-HCSD, which includes New Orleans, had nearly 900,000 outpatient visits, including 626,000 clinic visits during the 2005-2006 fiscal year.

Reimbursement for these services is primarily funded by utilizing disproportionate share hospital (DSH) funds. The DSH program was created to provide funding to hospitals that served a "disproportionate share" of Medicaid and uninsured patients and is a component of the Medicaid program. Subsequently, it is jointly funded by the state and federal governments. Louisiana's "state match rate" is approximately 30 percent – so for every thirty cents the state puts forward, the federal government matches it with seventy cents. Additionally, each state has a DSH cap. The total DSH available for Louisiana in fiscal year 2007 is \$1.05 billion.

DSH funds in Louisiana are primarily allocated to the LSU system and community hospitals. Although DSH funds are a key source of funding for the uninsured in Louisiana, there are some limitations to the program. For example, only hospitals can be reimbursed with DSH funds. This means that only hospital-based clinics can receive reimbursement through the DSH program. This is less of an issue for the LSU system, since it is an integrated system

with both hospitals and clinics. However, the DSH program inadvertently supports high-cost emergency department care when primary care through a clinic might be more appropriate. Furthermore, DSH funds are used for reimbursing health care services – but cannot be used to reimburse a physician or other health care professionals that provide care to the uninsured.

Louisiana is not unique in the existence of this type of safety net; we are unique in that it is organized as a statewide system. Through this system, people who are unable to afford health care can access services, including primary, preventive and specialty care as well as hospital services. While variable across the state, access to many services is constrained by available funding.

Considering the high utilization, rising costs, uneven quality, and lack of equitable access to health care in Louisiana, the state's approach to health care reform, both pre- and post-Katrina has been aimed at making systemic changes.

Louisiana Health Care Redesign Collaborative: After Hurricane Katrina, the Louisiana Health Care Redesign Collaborative was created through a legislative resolution to respond to the health care issues in the New Orleans region (Jefferson, Orleans, Plaquemines, and St. Bernard parishes). The Collaborative was a forty member group charged with creating recommendations for a health care system for New Orleans driven by quality and incorporating evidence-based practices and accepted standards of care. The Collaborative adopted the following vision: Health care in Louisiana will be patient-centered, quality-driven,

sustainable and accessible to all citizens. The backbone of a redesigned system of care put forward by the Collaborative is the "medical home."

The proposed medical home system is consistent with recommendations made by a number of professional societies such as the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians. It also has qualities and expectations consistent with those of a high performing health system as described by the Commonwealth Fund and of a redesigned system as characterized by the Institute of Medicine.

This new system will provide health promotion, disease prevention, health maintenance, behavioral health services, patient education, and diagnosis and treatment of acute and chronic illnesses. The medical home is the base from which other needed services are managed and coordinated in order to provide the most effective and efficient care. This includes specialty care, inpatient care, community preventive services and medical home extension services for complex care needs. The center of the medical home is a primary care provider who partners with the patient to coordinate and facilitate care. The medical home does not restrict patient access to services – rather it helps ensure that the patient receives the right services.

Ensuring the coordination and comprehensive approach of the medical home model over time will improve the efficiency and effectiveness of the health care system and ultimately improve health outcomes. The other three main components of the redesign concept are:

- Health Information Technology (HIT) HIT is the key to creating "system-ness" and can allow the seamless sharing of electronic information to improve efficiency and patient safety. Additionally, HIT can be used to inform clinical practices and facilitate data reporting which are key components of a quality agenda.
- Louisiana Health Care Quality Forum (LHCQF) –The LHCQF will function as a "learning system" that will monitor population health measures across providers and payer systems and actively engage with health care organizations to implement quality improvements, increase cost-effectiveness, and achieve better outcomes statewide. It will improve the quality of health and health care throughout Louisiana in a cost effective and transparent manner in a safe, peer protected environment.
- Coverage for Services Another major concept is the creation of a mechanism (the Connector) which would match individuals needing health insurance to affordable insurance options, thus offering affordable health insurance coverage to an expanded number of uninsured individuals in the state.

In response to the Collaborative's concept, the federal Department of Health and Human Services put forward a proposal that is consistent with the President's Affordable Choices Grants proposal that was announced in the 2007 State of the Union address. HHS proposed a statewide coverage expansion that would insure 319,000 uninsured through private insurance. This proposal would be financed by savings from better managing Louisiana's Medicaid program and by redirecting \$770 million in disproportionate share hospital (DSH) funds currently spent in the safety net system.

While appreciative of the effort to insure more individuals, the state recognizes serious gaps in the proposal. Through our analysis, the HHS proposal would leave 300,000 to 400,000 citizens without insurance coverage. Additionally, current funding (\$770 million) for the safety net would be eliminated if the state were to implement the CMS proposal. The use of incorrect cost projections, the omission of high-cost populations, and the use of unrealistic managed care discounts in the HHS proposal suggests that coverage would be expanded to fewer than the projected 319,000.

Louisiana has learned from those that have traveled this road before. Massachusetts, which is breaking ground with its mandate for health insurance coverage, spent many years working towards this goal. If Louisiana were to cover half of its uninsured as optimistically described above, we would end where Massachusetts began just prior to its 2006 reform legislation — about 10% uninsured but without a safety net system of care. As a state with nearly 18 percent uninsured and 45 percent of its population at 200% of the Federal Poverty Level or below, viii we understand that we must lay the groundwork before we can make such great leaps. The groundwork includes efforts aimed at both insuring more people, and also, very importantly, improving our safety net and the delivery system in general.

John Wennberg, Director of the Center for the Evaluative Clinical Services at Dartmouth Medical School, and others have demonstrated that in healthcare, capacity is a strong driver for demand. As a result of Katrina, the New Orleans region lost a large amount of capacity. However, capacity is tied to other important pieces of the utilization equation, such as how care delivery is coordinated and how it is reimbursed.

Those system design changes have not occurred; therefore we should not expect a smooth transition to a lower capacity system. Further, in most areas, capacity is now well below national norms. The lower capacity and specifically, the lack of ready access to coordinated primary care or post-acute care, has resulted in the stressed medical environment we are experiencing today in New Orleans.

So our challenge is twofold. We must first meet immediate needs while ensuring that, in the process, we support the rebirth of a better overall system of care. The vision for a system to replace the lost capacity is one that adheres to the aims set forth by the Institute of Medicine: safe, effective, patient-centered, timely, efficient, and equitable. It is a patient-centered system predicated on access to primary care that provides evidence-based preventive services and tracks those with chronic disease to ensure appropriate management. It provides ready access to appropriate services and information when necessary and is convenient for patients, coordinated among providers along the continuum of care, and supported by a system of electronic medical records to improve safety, quality and efficiency.

The current gaps in the delivery system have provided the opportunity for systems change. We will continue to move forward with health care reform for Louisiana – but we must also ensure the New Orleans region can recover to meet our citizen's health care needs today. My testimony today will focus on the immediate and short-term health care needs for the New Orleans region of Louisiana.

Post-Katrina Health Care in the New Orleans Region: Hurricane Katrina caused a significant disruption in the health care delivery system in New Orleans. Prior to Katrina,

care for the uninsured in the New Orleans region was delivered primarily in the public hospital system and clinics and to a lesser extent, federally qualified health centers (FQHCs). Uncompensated care for the community hospitals in the region was less than 4 percent. According to the PricewaterhouseCoopers Report on Louisiana HealthCare Delivery and Financing System, the region had an oversupply of short-term acute care hospital beds and an undersupply of long-term care beds.

Immediately after the storm, only 7 of 21 acute care hospitals were open with staffed beds at less than half of the pre-Katrina total. The nursing home capacity was reduced from 4,954 to 2,735 beds. The largest health care system for the uninsured, the LSU-HCSD system, was not operational. The closure of the LSU-HCSD hospital in New Orleans also eliminated their Level I trauma center, which was one of only two in the state. In addition to the impact on the infrastructure, the evacuation of people from the area led to the largest efflux of health care providers in U.S. history.

The University of North Carolina at Chapel Hill estimated that almost 6,000 active, patient-care physicians along the Gulf Coast were dislocated by the storm. Over two-thirds – 4,486—of those were in the three central New Orleans area parishes that were evacuated. The study also estimates that over 35 percent of these dislocated physicians were primary care physicians. The loss of medical manpower in hurricane-affected areas created a critical shortage of physicians all across south Louisiana. Similar shortages have occurred with nurses and other licensed and trained health care providers.

There have been a number of efforts over the past year and a half to ameliorate the situation in the New Orleans region. The federal Deficit Reduction Act appropriated \$2 billion to states affected by Hurricane Katrina. As a result, the state implemented a Katrina 1115 waiver to provide coverage to our citizens that evacuated to other states and to provide payment to providers within the state for uncompensated care (UCC). This provided \$132,091,048 in much needed relief to providers for uncompensated care between August 2005 and January 2006.

Additionally, the state was able to use approximately \$680,569,383 to supplement state funding for its Medicaid program. The Medicaid funding relief came at a critical juncture in early 2006 as state revenues had sharply declined, all state agencies were implementing budget reductions, and the state had issued an emergency rule reducing Medicaid reimbursement rates to providers by roughly 10 percent.

Hospitals: Recognizing that the usual source of inpatient care for the uninsured in the Orleans region was not operational and that the Katrina UCC pool was time limited, the state created a mechanism to pay community hospitals for UCC rendered for the remainder of the state fiscal year, between February and June 2006. A total of \$52,494,904 was reimbursed to community hospitals. Currently, physician costs are not considered an allowable cost and cannot receive reimbursement through the DSH program. A request to receive federal match to pay physician UCC during this period was requested but not approved.

Two payment increases were subsequently approved by the 2006 Louisiana Legislature. First, Medicaid payments for hospitals were increased by \$38 million. Second, a *Community Hospital DSH Pool* was established, allocating \$120 million for UCC for community hospitals from July 2006 through June 2007. Although a proposal was put forward by the state to reimburse hospitals in the Katrina and Rita affected parishes at 90% of uncompensated care costs, the hospital association preferred an approach that provided less funding to the Katrina and Rita affected regions and spread the UCC funds more thinly across the state to potentially include all hospitals in the state, including those not in the affected regions and not significantly impacted by evacuees.

To date, \$37,995,972 has been paid to the community hospitals; it is likely that the full \$120 million will not be expended according to the formula adopted in the state appropriations bill.

Primary Care and Behavioral Health: Access to primary care and behavioral health has been limited post-Katrina. This is particularly true for those without insurance. Approximately \$16.5 million of the Social Services Block Grant (SSBG) funding was dedicated to restoring primary care in the New Orleans region after Hurricane Katrina to restoring critical primary and preventive health care services. This funding expires August 2007. In addition to utilizing this funding for direct service delivery, SSBG funding also has been used to enable these clinics to prepare to become future medical homes delivery sites. The state targeted a portion of SSBG funding to the implementation of electronic medical records, quality improvement initiatives and the development of networking capabilities across clinic sites to achieve interoperability and system-wide patient education and outreach.

SSBG funds are also being used to restore and expand mental health services, substance abuse treatment and prevention, and developmental disability services for children, adolescents and adults in need of care in these areas. Through this funding, efforts are also being targeted at the creation of more appropriate community based treatment options to prevent unnecessary or inappropriate institutional care.

Federal Emergency Management Agency (FEMA) and Substance Abuse and Mental Health Services Administration (SAMHSA) funds have been used to:

- provide psychological debriefing and stress management interventions to the public sector workforce;
- expand the number of addiction counselors in the state; and
- develop and implement the "Louisiana Spirit" Immediate Crisis Services Program,
 which is designed to deliver crisis and mobile counseling to persons impacted by the hurricanes.

The state has also provided funding to open 45 beds for behavioral health for adults and children.

Health Care Workforce: The Redesign Collaborative identified a number of short-term issues and made requests to HHS for assistance, including one to establish the Greater New Orleans Health Services Corps (GNOHSC). A major challenge remains the inability to retain a medical workforce. HHS awarded Louisiana with a workforce grant of \$15 million in February 2007.

The grant, through the GHNOHS, will provide salary, relocation costs, bonuses, and premium payments for medical malpractice for providers that commit to practice in the region for the next three years. Eligible providers include physicians, dentists, physician assistants, nurse practitioners, nurse midwives, dental hygienists, psychologists, counselors, social workers and pharmacists.

New workforce competition, as a result of Katrina, has highlighted traditionally low salaries of direct care professionals for the elderly and people with disabilities. The average salary for direct support professionals in Louisiana is \$6.68, which is below the national average. The state is increasing the wages for these workers by \$2/hours to help retain these critically needed workers. The annual cost to Medicaid will be \$110 million.

Another short-term request from the Collaborative to HHS was for an adjustment to the Medicare wage index to reflect current costs. The wage index typically lags three years. Hospitals estimated the cost to be \$67.7 million a year for three years. A \$71 million grant to hospitals and skilled nursing facilities was received from HHS.

Health Information Technology: Louisiana received a \$3.7 million contract from the Office of the National Coordinator for Health Information Technology (ONCHIT) to develop a prototype for health information exchange, which has since been successfully demonstrated. This contract is part of the Gulf Coast Digital Recovery Effort. The state assisted in the establishment of the Gulf Coast Health Information Technology Task Force that the Southern Governor's Association convened. Other HIT efforts include the launch of

KatrinaHealth.org which allowed providers to access prescription drug information for evacuees.

Current Status of the System: Combined, these efforts have significantly improved health care in the New Orleans region. However, issues remain. Over time, the impacted area has seen slight increases in bed capacity, but there remains a shortage of acute care beds compared to national standards. The current plan in the LSU-HCSD hospitals is to phase-in an additional 75 beds by July of 2007. The staffing and reimbursement for hospitals continue to pose problems.

Today, there are 26 safety net primary health care sites that are providing services in the New Orleans region. These sites include federally qualified health centers, Tulane outpatient clinics, LSU-HCSD outpatient clinics, mobile clinics, city and parish health service sites, hospital outpatient clinics, rural health clinics and non-profit community-based practices. However, based on the current population, there remains a shortage of primary care providers. Increased demand for primary care providers will likely occur as the region continues to repopulate.

The region also suffers from a significant shortage of specialists. While LSU-HCSD has been able to resume a number of specialty services as space and staff have become available, there remains the lack of some essential specialty services to support the primary care sites serving Medicaid and the uninsured. The area is still below national norms for nursing facility beds.

Immediate Health Care Needs for the New Orleans Region: The health care system is still challenged today. The actions taken over the past year and a half have helped to improve access to care, workforce issues and infrastructure – but problems remain. Access to care, particularly for the uninsured, is difficult. Rising costs, due to contract labor and higher property and casualty insurance costs are impacting providers. The average length of stay in hospitals is above pre-Katrina averages. These are among the immediate needs to be addressed in the New Orleans region.

Broadly, the immediate continuing needs fall into one of three categories: access to care, workforce recruitment and retention, and infrastructure requirements. The specific needs are outlined below:

Primary Care Capacity: Currently, there is a shortage of primary care providers in the New Orleans region that is affecting all other components of the system. Based on HRSA standards, we have a shortage of 49 primary care providers who are available and willing to serve the Medicaid and uninsured populations. Hospitals across the region report seeing a population with more advanced disease than pre- Katrina, more patients without a regular source of care, and even more limited options for discharge and follow-up care in the communities.

Solution: Establish sufficient primary care capacity in a manner consistent with the redesigned system of care envisioned by the Collaborative by sustaining operational support provided by SSBG funds to safety net clinics and by funding ten new medical homes. Medical Homes of sufficient size and scope to meet the needs of the uninsured population will be established in a fashion consistent with the

principles outlined by the Collaborative. The medical home criteria would include not only quality expectations but also care coordination and access expectations to ensure timely care is available outside of emergency departments through after hours clinics.

The above approach will have the effect of providing assurances of income necessary to attract and retain providers, while relieving the burdens of fixed costs. This will foster the growth of what is designed to be a high performance delivery system.

Workforce Recruitment and Retention: Louisiana facilities now have to employ increasing amounts of contract labor to sustain staffing needs. The added complexity of inadequate and short supply of desirable housing for health care professionals continues to result in a lack of physician staff, mental health professionals, dentists, nurses, and others willing to remain in or locate in the greater New Orleans area. The ability to expand capacity to meet the health care needs in the region is hindered by the lack of available workforce.

Solution: Fully implement the Greater New Orleans Health Services Corps Program. Initially, Louisiana requested \$120 million to support health care workforce recruitment and retention. Fifteen million dollars have been granted to the state – which will allow the state to institute the program. However, we continue to estimate that it will cost \$120 million to fully implement the program. This will provide for incentives for physicians, dentists, nurses, and other professional staff. In exchange for the financial support, providers must commit to serve in the region for three years.

Behavioral Health: Lack of access to necessary community based services and housing supports for individuals with mental illness and other behavioral health needs shifts care to more acute services. The shortage of community services for this population, a situation only exacerbated after Hurricane Katrina, results in the reliance for services on the hospital emergency departments, an area already strained due to the lack of adequate primary care in the area. In addition, the loss of psychiatric care beds in the area from 274 to 180 post-Katrina and the slow return of the community based mental health services only furthers the lack of access to care.

Solution: Develop, implement, and fund a five year redevelopment and mitigation / prevention plan for behavioral health services; and expand Medicaid coverage to people with severe mental illness. The state requests a partnership with FEMA and other governmental entities in the development and implementation of a point by point plan along with secure funding for a five years. This plan allows for the reestablishment of a competent mental health system in the greater New Orleans region and other contiguous parishes.

This five year plan, estimated at \$170,000,000 would include crisis counseling under the existing FEMA Disaster Relief, as well as direct treatment dollars for services including psychiatric hospitalization, crisis intervention, suicide prevention, substance abuse treatment and long-term ambulatory treatment of psychiatric conditions. This funding and support from FEMA will stabilize the behavioral health system for the Orleans region.

Further, the concept paper the state put forward to HHS included a request to include individuals with serious mental illness as a Medicaid eligible population. This would allow the state to provide broader access to services for these individuals.

Medicare Wage Index: The short supply of health care providers is resulting in increased competition among providers for professional and non-professional staff. The effect is a significant rise in labor costs. Compounding the problem is the increase in the length of stay that hospitals are reporting. This rise in costs is not reflected in the prices established by the Medicare fixed payment system.

Solution: Provide funding for costs related to the Medicare wage index. HHS awarded Louisiana a \$71 million grant for hospitals and skilled nursing facilities to address the increased costs providers are experiencing as a result of the rising labor costs. While very helpful, this one time grant does not address the entire three year lag in the Medicare wage index calculation. The fiscal estimate for two years is \$67 million/year for hospitals and \$6.9 million/year for skilled nursing facilities.

DSH Flexibility: Two significant roadblocks to increasing health care capacity and access to health services in the New Orleans region are (1) the inability to use DSH funding for non-institutional care and (2) the inability to use DSH to reimburse for physician services. In order to receive DSH funds today, health care services must be funded by a hospital. While the state has created great capacity in a clinic system associated with public hospitals, this limits flexibility in development of outpatient capacity. Further, while physician costs are an essential component of delivering health care, they are not reimbursable through DSH.

Solution: Allow the redirection of DSH funds to support non-institutional care; and allow DSH funds for physician services. The DSH redirection will provide great relief by creating a funding mechanism to reimburse physicians for treating the uninsured and by supporting clinics that provide primary and preventive care. The state also proposes to redirect DSH funds in the New Orleans region for a pilot to reduce the cost of private insurance for small employers and their low-income employees. Ultimately, redirecting the DSH funds will allow the groundwork for creating an integrated system of care for the New Orleans region. This solution does not require additional funding.

Health Information Technology (HIT): Hurricane Katrina highlighted the importance of interoperable HIT. After the storm, providers had difficulty communicating with each other across the state and the vast majority patients who were displaced as well as the providers caring for them did not have access to patient records. While HIT is an important component of hurricane preparedness, it creates value everyday by improving patient safety and health system efficiency. As physician practices recover, and as we support providers in settings to care for the uninsured, it makes sense to implement a modern system of health information exchange into the process. The devastation in the New Orleans region provides an unprecedented opportunity to make a significant imprint of HIT in a large metropolitan area.

Solution: Support electronic medical record (EMR) adoption and continue to support the Louisiana Health Information Exchange (LaHIE) project. The Office of the National Coordinator for Health Information Technology contracted with Louisiana immediately after Hurricane Katrina to

develop a health information exchange, as part of the Gulf Coast Digital Recovery effort. This \$3.7 contract will expire at the end of this month. Continued support of LaHIE will cost approximately \$1 million per year. The other essential component is the adoption of EMRs by providers. The state estimates that it will cost \$17.7 million over a five year period for the New Orleans region primary care providers to fully adopt EMRs. The state is would like to continue and expand this successful partnership with the federal government.

Developmental Disabilities: The ongoing need for community-integrated housing that can support those with significant disabilities is critical for the recovery and for the healthcare delivery system in south Louisiana. Prior to Hurricanes Katrina and Rita, people with disabilities were disproportionately represented among the homeless and faced extraordinary barriers in accessing and maintaining access to affordable housing. As a result of the disaster, many more have been rendered homeless or have been unable to move from what should have been temporary shelter in institutions and other restrictive settings because of a lack of affordable housing coordinated with supportive services. This also affects the ability of healthcare providers to discharge individuals from acute care settings, and housing instability often leads to a revolving door of reentry into emergency and acute care services.

Solution: Provide, through the U.S. Department of Housing and Urban Development, an equal number of Section 8 project-based Housing Choice Vouchers to be used in conjunction with the 3,000 units of Permanent Supportive Housing (PSH). Louisiana has made a commitment to develop 3,000 units of Permanent Supportive Housing as part of the recovery effort. The state has worked closely with local and national advocates who are strongly in favor of this commitment to PSH. These vouchers will ensure that the housing designated for PHS will,

in fact, be affordable to individuals with disabilities, many of whom live on SSI and have incomes at and below 20% of Area Median Income. In order for this recovery to be accessible to all Louisianans, the federal government's provision of 3,000 Section 8 project-based Housing Choice Vouchers specifically for use in providing PHS as defined in the Louisiana Road Home Plan is essential.

PSH integrates affordable, mainstream rental housing with the supportive services needed to help people with disabilities access and maintain stable housing in the community. This model is a nationally recognized, cost-effective model for preventing and ending homelessness and unnecessary institutionalization among low-income people with serious, long-term disabilities including mental illness, developmental disabilities, physical disabilities, substance use disorders, chronic health conditions like HIV/Aids, and chronic conditions and frailty associated with aging.

Thank you for the opportunity to testify today.

ⁱ PricewaterhouseCoopers, "Report on Louisiana Healthcare Delivery and Financing System," 2006.

ii Families USA, "Premiums Versus Paychecks: A Growing Burden for Louisiana's Workers," December

iii S.F. Jencks, et al, "Change in the Quality of Care Delivered to Medicare Beneficiaries," JAMA, 2003.

iv Kaiser Family Foundation, State Health Facts – Louisiana, available at: www.statehealthfacts.org (accessed March 9, 2007).

v Jencks

vi J.R. Graham, "Don't blame the uninsured," Chicago *Tribune*, March 2007.

vii LSU-HCSD, "LSU-HCSD Fiscal Year 2005-2006 Utilization Report," May 2006.

viii Kaiser Family Foundation, State Health Facts – Louisiana, available at: www.statehealthfacts.org (accessed March 9, 2007).

ix PricewaterhouseCoopers, "Report on Louisiana Healthcare Delivery and Financing System," 2006.